APPENDIX A

NOTICE OF VIOLATION

Arizona Public Service Company
Palo Verde Units 1, 2, and 3

Docket Numbers 50-528, 50-529, and 50-530
License Numbers NPF-41, NPF-51, and NPF-74

During an NRC evaluation conducted over the period November 6-17 and December 4-8, 1989, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1990), the violations are listed below (with reference to the applicable DET Report paragraphs):

I. Failure to Follow Procedures or to Have Adequate Procedures

10 CFR Part 50, Appendix B, Criterion V, states in part that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings.

A. Surveillance Testing

Surveillance Test Procedure 43ST-3SI06, Revision 1, "Iodine Removal System - S.C.A.P. Discharge Flow and Pressure Test," Step 8.2.12, states for the "A" Train Spray Chemical Addition Pump suction valve, a safety related valve, "close SIA-UV-603 using handswitch SIA-HS-603."

Contrary to the above, on December 5, 1989, during the performance of procedure 43ST-3SI06, a Unit 3 licensed control room operator failed to close SIA-UV-603 at step 8.2.12, and mistakenly documented that SIA-UV-603 had been closed.

(DET Report Paragraph 3.2.3.6)

B. Motor Operated Valves

1. Contrary to the above, as of the DET evaluation, Document No. 13-J-ZZI-004, Revision 5, (the licensee's motor operated valve (MOV) data base document) was inappropriate for the control of MOV setpoints in that:

(a) On November 13, 1989, qualified technicians were observed by QA personnel to select incorrect limit switch settings while working on a safety-related valve, 2JAFBHV0030. Document No. 13-J-ZZI-004, Revision 5, had 34 Drawing Change Notices (DCNs) which had not been incorporated and caused confusion for personnel using it.

(b) The MOV setpoints specified in Document No. 13-J-ZZI-004 were not supported by reviewed and approved setpoint calculations.

2. Limitorque allows an operator to exceed the published rated output thrust by 10 percent as long as the operator is limited to 100 lifetime cycles. Contrary to the above, as of the DET evaluation, instructions appropriate to the circumstances had not been established to track the number of cycles an overthrust condition occurred on such a valve so that the recommended number of cycles would not be exceeded.

3. Contrary to the above, as of the DET evaluation, instructions appropriate to the circumstances had not been established in that Notes 14 and 15 of Document No. 13-J-ZZI-004 were contradictory in whether torque switch limiter plates were to be left in place or removed after MOVATS testing.

(3.3.8.1, 3.3.6.2, 3.6.15.2, 3.3.8.3)

C. Maintenance

1. Contrary to the above, on October 23, 1989, Atmospheric Dump Valve 3J-SGB-HV0178 was repacked using Maintenance Procedure 31MT-9SG04; however, packing rings of an incorrect thickness were installed due in part to an inadequate valve packing procedure.

2. Contrary to the above, on November 9, 1989, procedures were not followed in that maintenance personnel mistakenly installed parts from the Containment Purge Exhaust Valve 3J-CPA-UV02B on the Containment Purge Supply Valve 3J-CPB-UV03A and QC personnel also mistakenly signed off hold points not in accordance with the directions specified on Work Order 389094 for this work.

3. Contrary to the above, on October 28, 1989, instructions were not followed in that Diesel Generator A for Unit 2 was found with a cylinder indicator cock open. Work Order 380644, completed on October 28, 1989, specified that the cylinder indicator cock be closed after completion of the work.

(3.3.10)

D. Steam Generator Chemistry Control

Procedure 74AC-9CY04 requires for steam generators in long term layup (greater than four days) a nitrogen overpressure of greater than 5 psig and that sampling and analysis be performed three times per week.

Contrary to the above, from May 1989 through November 1, 1989, while the steam generators in Units 1 and 3 were in long term wet layup, the nitrogen overpressure in the steam generators had not been maintained. In addition, from September 25, 1989, through

November 1, 1989, the Unit 1 steam generators had not been sampled.

(3.6.4.2)

These items (I.A, I.B.1-3, I.C.1-3, and D) each constitute a Severity Level IV violation (Supplement I) applicable to Units 1, 2, and 3.

II. Failure to Take Appropriate Corrective Actions

10 CFR Part 50, Appendix B, Criterion XVI, states in part that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective actions taken to preclude repetition.

A. Contrary to the above, as of the DET evaluation, during the replacement of a bent valve stem for Auxiliary Feedwater Control valve 3AFBHV030, a significant condition adverse to quality, corrective actions to preclude repetition were inadequate in that the replacement valve stem was also bent. (3.3.4.1, 3.6.4.5)

B. Contrary to the above, as of the DET evaluation, the licensee failed to take adequate actions to correct conditions adverse to quality as follows:

1. The licensee's response to a Part 21 notification from Limitorque regarding degraded insulation in type SMB actuators with direct current motors, issued in November 1988, was closed concluding that no motor operators were affected. However, on October 28, 1989, it was found that some actuators (type SB) were similar to and used the same style motor as noted in the Part 21 notification.

2. The licensee's response to Information Notice 85-22 was closed on July 5, 1985 concluding that Limitorque technical manuals would be updated to provide necessary information such as proper motor pinion position; however, as of the time of the DET evaluation updated manuals had not been approved.

(3.3.8.5)

C. Licensee Event Report (LER) 85-096, issued on January 27, 1986, described that the seismic gap area between the Diesel Generator Building and the Control Building of each unit at Palo Verde had not been properly analyzed in the Fire Hazards Analysis. Contrary to the above, this significant condition adverse to quality was not precluded from repetition in that on October 23, 1989, the licensee identified four additional openings in the same wall.

(3.6.7.9)

These items (II.A, B, and C) each constitute a Severity Level IV violation (Supplement I) applicable to Units 1, 2, and 3.

Pursuant to the provisions of 10 CFR Part 2.201, Arizona Public Service company is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555, with a copy to the Regional Administrator, Region V, and a copy to the NRC Resident Inspection office at the Palo Verde Nuclear Generating Station, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation; (2) the corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken to avoid further violations; and (4) the date when full compliance will be achieved. If an adequate reply is not received within the time specified in this Notice, an order may be issued to show cause why the license should not be modified, suspended or revoked or why such other action as may be proper should not be taken. Consideration may be given to extending your response time for good cause shown.

FOR THE NUCLEAR REGULATORY COMMISSION

SIGNED FOR

R. P. Zimmerman, Director
Division of Reactor Safety
and Projects

Dated at Walnut Creek, California
this 17TH day of July 1990